920 Medical Plaza Dr.
Suite 450
The Woodlands, TX 77380
PH: 281-364-1700
FAX: 281-364-1710
Website: www.htechfamily.com

NEW ADULT PATIENT HISTORY INTAKE

Welcome to **High Tech Family Care**. In order for us to better serve you; please take the time to fill out this entire packet as accurately as possible so we can adequately address your health needs and/or concerns.

PERSONAL HISTORY

Name: ____

Gender: ☐ Male ☐ Female Social Security #: ____ – ______ – ____

Date of Birth:____/____/____ Age: ________

Home Address: ________________________ City, State, Zip __________________

Telephone: Home (___)____________________Cell (___) _________________________

Email: ____

Ethnicity: White/Caucasian ☐ Black/African American ☐ Asian/Pacific Islander ☐

Hispanic/Latino ☐ Native American ☐ Other ____ ☐

Spouse/significant other:_______________________________Tel:(___)____________

Occupation_________________________Employer: ____

Employer Address:___________________________City_______________________Zip Code____________

Date of Last Examination__________________Your Doctor: ____

Referred by:____

Are we authorized to send lab results or medical interface to this email address? ☐ NO ☐ YES

Allergies: ☐ NO ☐ YES **If "yes," explain**: __________________________________

INSURANCE INFORMATION

Primary Insurance Carrier's Name: __________________________________

Address: _____________________________________ City, State, Zip: _______________________

Insurance Member ID #: _____________________ Group #: ___________________

Policy Holder's Name: ____________________________

Date of Birth_______/_______/______Social Security #: ____ – ______ – ____

Name & Address of Employer: ____

Your signature below indicates your consent for treatment of patient and your responsibility for payment of services provided. Thank you.

___________________________ ______________________

Signature Date:

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Reason(s) for this appointment: (if possible, rank in order of severity)

1. ____ 3. ______________________________________
2. ____ 4. ______________________________________

Medications/Supplements: What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you currently taking? Indicate the dosage and frequency for each medication/supplement.

1. ____ 3. ______________________________________
2. ____ 4. ______________________________________

Past Medical, Surgical & Trauma History: (List prior illnesses, injuries, hospitalizations, surgeries, and/or traumas*)*

Condition(s): **Date(s):**

____ ___________________________

____ ___________________________

SOCIAL HISTORY

Marital status: ☐ single ☐ married ☐ divorced ☐ widowed
Education level completed: ☐ below high school ☐ high school ☐ college ☐ professional/trade school
Living arrangement: ☐ alone ☐ family ☐ roommate ☐ significant other
Children: (list sex/ages if applicable):___________________________
Major stresses in last 6 months: ☐ Finances ☐ Job ☐ Marriage ☐ Home Life ☐ Other
"**if other explain**":__________________________
Any recent travel? ☐ NO ☐ YES **If "yes," when/where**: __________________________

Do you smoke?	☐ NO ☐ YES	If yes, how many packs per day _____ for _____ year(s)
Did you ever smoke?	☐ NO ☐ YES	If yes, when did you quit?_____after___years.
Drink alcohol?	☐ NO ☐ YES	If yes, _____ amount/ ____ per week
Drink caffeine?	☐ NO ☐ YES	If yes, what type? ______________
Do you exercise regularly?	☐ NO ☐ YES	If no, why not? ___________________
Use recreational drugs?	☐ NO ☐ YES	If yes, what kind? ___________ how often? _______
Manage stress well?	☐ NO ☐ YES	☐ NOT SURE ☐ NEED HELP

List the date of your most recent test or exam. Mammogram ___________Pap Smear __________
Colonoscopy ________ Blood test for Cholesterol ________ Blood Sugar _______Other Blood Tests ___________

Immunizations: Tdap _____Hepatitis ______ Pneumonia _____Flu Shot_______ Others: ____________________

Recent Radiographic Procedures: (X-ray, MRI, CT Scan, Ultrasound, Bone Scan, Pet Scan, etc):	
Type of Procedure	**Date(s)**

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PERSONAL AND FAMILY HISTORY (Check all that apply)							
	Self	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS/STDs							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Heart Attack							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Other							

EMERGENCY CONTACT (When parent/guardian is unable to be reached)			
NAME *(list at least 3 contacts)*		**PHONE**	**RELATIONSHIP**
1.			
May we disclose all medically needed documents to this emergency contact? ☐ NO ☐ YES			
2.			
May we disclose all medically needed documents to this emergency contact? ☐ NO ☐ YES			
3.			
May we disclose all medically needed documents to this emergency contact? ☐ NO ☐ YES			
Advance Directive: ☐ Full code *or* ☐ Do Not Resuscitate			

This history record has been designed to facilitate our patient's continuity of care at **High Tech Family Care**. This is a confidential record. Information contained here will not be released without proper written authorization.

____ _____________________

Physician Signature Date

____ _____________________

Signature of individual completing form Date

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